

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18711

8725

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3½ hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Viola	Last Anderson
4. DATE OF DEATH Aug. 23 1956	Month Aug.	Day 23	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rollup finishing Dept Silk Mill		9. AGE (In years from birthday) 43 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Russel Davis		14. MOTHER'S MAIDEN NAME Lula Guessford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-20-0502	
No		17. INFORMANT Mr. Russel Davis 145 N. Conococheague St Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 hrs Cerebral Hemorrhage	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 23/56</u> to <u>Aug. 23/56</u> , that I last saw the deceased alive on <u>Aug. 23/56</u> , and that death occurred at <u>Williamsport</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED Aug. 23/56 Albert L. Leaf Williamsport, Maryland	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26-56	
22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Maryland		24a. REC'D BY REGISTRAR Aug. 27, 1956	
		24b. REGISTRAR'S SIGNATURE Albert L. Leaf Williamsport, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date:

Place:

Cause:

Age:

Sex:

Race:

Signature:

BUREAU V. S.

AUG 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8726

CERTIFICATE OF DEATH

Reg. Dist. No.

18712
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 38 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 N. Cannon Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) Maria		First ---	Middle Ansley
4. DATE OF DEATH Aug	Month August	Day 30	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1876
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Near Clearspring Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Abraham Roth		14. MOTHER'S MAIDEN NAME Amanda Grosh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. --	
17. INFORMANT Miss Bertha A. Roth		Address Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months certain	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive cardiovascular disease</u> <u>Arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? 10 years 2 years YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 21</u> , 1956, to <u>Aug 30</u> , 1956, that I last saw the deceased alive on <u>Aug 28</u> , 1956, and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above. D.S.P. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W.T. Layman</u>		M.D. 100 Professional Arts Bldg. 8-31-56	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-1-56	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE Sept 4, 1956		24b. REGISTRAR'S SIGNATURE B. H. Flowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b. Funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DESIGN

UNITED STATES GOVERNMENT OF INVENTIONS AND DESIGNS

BUREAU V. 2

SEP. 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8727

CERTIFICATE OF DEATH

18713
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wa.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Maryland RFD		d. STREET ADDRESS Antietam	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mammie		First Rebecca	Middle Baker	4. DATE OF DEATH Aug.	Month	Day 20	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19 1884		9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or Foreign country) Antietam Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Kretzer		14. MOTHER'S MAIDEN NAME Annie Ozelberger					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John Grey		Address Sharpsburg Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 385X		Pulmonary Embolism				INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Operation for cataract				2 weeks	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 1950 _____, 19 _____, to _____ 8/21/56 _____, 19 _____, that I last saw the deceased alive on _____ 8/20/56 _____, 19 _____, and that death occurred at 12:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walter H. Shealy</i>						ADDRESS (Street, city or town, state) M.D. Sharpsburg, Md.	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.						DATE SIGNED 8/23/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23-56		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert J. Leaf Williamsport, Md.</i>		ADDRESS Aug. 23-56		24a. REC'D BY REGISTRAR Aug. 25, 1956		24b. REGISTRAR'S SIGNATURE <i>Robert H. Bowers</i>	

CERTIFICATE OF QUALITY

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68714
Dr Wells
Reg. Dist. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8762

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN 1b 64 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 High St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
3. NAME OF DECEASED (Type or print) BERNARD ROBERT BALL		d. STREET ADDRESS 6 High St	
3. SEX Male		4. DATE OF DEATH August 12 1958	
5. COLOR OR RACE White		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> March 1 1892	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk W.I.R.R. Retired	
11. BIRTHPLACE (State or foreign country) Funkstown Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard M. Ball		14. MOTHER'S MAIDEN NAME Thalia V. Boteler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-10-7376	
17. INFORMANT Mrs Ola R. Ball		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease	
DUE TO 420.0		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute coronary occlusion			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells, M.D.</i>		DATE SIGNED 8-13-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/56	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Funkstown Cemetery		22d. LOCATION (City, town, or county) (State) Funkstown Wash. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR Aug 15 1958	
		24b. REGISTRAR'S SIGNATURE Robert K. Powers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to a Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
BUREAU X.

AUG 17 1956

WEDNESDAY EXAMINER'S EDITION OF SEATON

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

18715

8763

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOONESBORG		c. LENGTH OF STAY IN lb 6 MO.	
d. NAME OF HOSPITAL (If got in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. STREET ADDRESS 733 VIRGINIA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BESSIE	Middle LAURA	Last BARGER
4. DATE OF DEATH	Month AUGUST		Day 20
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/25/1881
9. AGE (In years less birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME WILLIAM DAVID BARGER		14. MOTHER'S MAIDEN NAME LAURA BELLE SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. NELLIE SHANK	18. CITIZEN OF WHAT COUNTRY? HAGERSTOWN MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 4, 1956 , to Aug 20, 1956 , that I last saw the deceased alive on Aug 19, 1956 , and that death occurred at 1 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. LeVan M.D.	ADDRESS (Street, city or town, state) Doonesboro		DATE SIGNED end.
22a. BURIAL, CREMATION, REMOVAL BURIAL	22b. DATE THEREOF 8/22/56	22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	22d. LOCATION (City, town, or county) HAGERSTOWN (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.	ADDRESS W. J. Norment, Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE 8/22/56	24b. REGISTRAR'S SIGNATURE Jane H. Dail

BUREAU V. S.

1956 25 511

RECEIVED
MAY 1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Welty

88716

CERTIFICATE OF DEATH

Reg. Dist. No. 303

8728

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hagerstown		c. LENGTH OF STAY IN 1b 5 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 103 Cypress St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 Cypress St.				d. STREET ADDRESS 103 Cypress St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) RUTH		First	Middle	Lost	4. DATE OF DEATH August 14 1956	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb 3 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greencastle Pa		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Beard		14. MOTHER'S MAIDEN NAME Urilla Gossard						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 220-30-890		17. INFORMANT Karl N. Beard 103 Cypress St Hagerstown		Address		
						d.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42d.1		Pulmonary Edema, Acute				10 min.		
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost } (b) DUE TO		Myocardial Infarction				7 weeks		
} (c) DUE TO		Coronary Arterosclerosis				4 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month. Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown		20f. (City or town) Hagerstown		(County) (State)
21. I certify that I attended the deceased from October 2, 1946, to August 13 1956, that I last saw the deceased alive on August 13, 1956, and that death occurred at 12 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE Dalton M. Welty		M.D.		August 15, 1956				
PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		Hagerstown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, sh. Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Colman, H. er. town i.d.		ADDRESS		24a. REC'D BY REGISTRAR Aug. 17, 1956		24b. REGISTRAR'S SIGNATURE G. H. Powers		

LEAU V. S.

Aug 20 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8729

CERTIFICATE OF DEATH

68717
302

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Wash. D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carlock Convalescent Home		d. STREET ADDRESS 323 cDowell Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Washington Benchoff		First Middle Last	4. DATE OF DEATH Aug. 6 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1870
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Telegrapher		10b. KIND OF BUSINESS OR INDUSTRY W. A. R. K. Co.	11. BIRTHPLACE (State or foreign country) Monterey, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Washington Jaret Benchoff		14. MOTHER'S MAIDEN NAME Hester Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Mrs. Richard Huffer, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-56</u> , 19, to <u>8-6</u> , 1956, that I last saw the deceased alive on <u>Aug 4</u> , 1956, and that death occurred at <u>Hagerstown</u> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>A. J. D. Smith</u> M.D. ADDRESS (Street, city, town, state) <u>Hagerstown, Md. 21701</u> DATE SIGNED <u>Aug. 9, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-1956	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Aug. 9 Dawson Hagerstown Md.		24a. REC'D BY REGISTRAR Aug. 9 1956	
24b. REGISTRAR'S SIGNATURE B. J. Dawson			

BONNEY V. B

1950

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8718

8730

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS CLEVELAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WALTER	Middle LAWRENCE	Last BERRY	4. DATE OF DEATH Month AUGUST	Day Year 29 19 56
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1888	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE PAINTER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		11. BIRTHPLACE (State or Foreign country) VIRGINIA	
13. FATHER'S NAME WALTER H. BERRY		14. MOTHER'S MAIDEN NAME SARAH ADAMS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO 219-05-2795		17. INFORMANT MRS. ANGELINE FOUGE	
				Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
Dr. Meura / Ohydrs. Negrosis Cathexis Sclerosis. ? None ?					
INTERVAL BETWEEN ONSET AND DEATH 15 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 8, 1956, to Aug 29, 1956, that I last saw the deceased alive on Aug 28, 1956, and that death occurred at 3 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. H. Beachley M.D. ADDRESS (Street, city or town, state) Hagerstown, MD DATE SIGNED Aug 31, 1956					
22a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		22b. DATE THEREOF 8/31/56		22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	
22d. LOCATION (City, town, or county) HAGERSTOWN				(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Torment, Hagerstown, MD					
24a. REC'D. BY REGISTRAR DATE Sept. 4, 1956					
24b. REGISTRAR'S SIGNATURE W. J. Torment, Hagerstown, MD					

BUREAU V. 8

SEP 6 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68719

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1150 the Terrace		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1150 the Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JACOB	Middle ABRAHAM	Last BIBERMAN	4. DATE OF DEATH August	Month 26	Day 1956	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1893	9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 1	12. IF UNDER 24 HRS Hours 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary-Treasurer		10b. KIND OF BUSINESS OR INDUSTRY Dress company		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Abraham Biberman			14. MOTHER'S MAIDEN NAME Feiga ?			Address Hagerstown, Maryland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no		16. SOCIAL SECURITY NO. 163-05-0591		17. INFORMANT Mrs. Mildred Biberman		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO acute coronary occlusion 1150.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO arteriosclerotic (coronary) heart disease (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Washington	(State) Maryland			
21. I certify that I attended the deceased from <u>7/15/1956</u> to <u>8/26/1956</u> , that I last saw the deceased alive on <u>8/26/1956</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE John H. Hornbaker, M.D.								ADDRESS (Street, city or town, state) Hagerstown - Md DATE SIGNED 154 W. Washington St - Hagerstown - Md
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/30/1956	22c. NAME OF CEMETERY OR CREMATORIUM Montefiore Cemetery	22d. LOCATION (City, town, or county) Philadelphia				(State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home John H. Hornbaker	ADDRESS Hagerstown, Md.	S	24a. REC'D BY REGISTRAR DATE 4	24b. REG. STAFF'S SIGNATURE Chester Bowes				

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

BUNZAU V. A.

SEP

1932

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18720

Dr. F. Young

8732

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EILEEN ALICE BRUNNER, Sr.		First	Middle
4. DATE OF DEATH August 25, 1956		Last	Month
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 11, 1914		9. AGE (In years less birthday) 42 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Cavetown, Maryland	
11. BIRTHPLACE (State or foreign country) Cavetown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tyson E. Brunner		14. MOTHER'S MAIDEN NAME Elsie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. 7-09-1300	
17. INFORMANT Mrs. Bernadette L. Brunner, 35 E. Antietam		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 months 6 mo. - 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1, 1956, to 8/25, 1956, that I last saw the deceased alive on 8/23, 1956, and that death occurred at 930 N. Antietam St., Hagerstown, Maryland, from the causes and on the date stated above. ADDRESS (Street, city or town, State) 135 N. Ant. St. 8/25/56, Hagerstown, Maryland DATE SIGNED 135 N. Ant. St. 8/25/56, Hagerstown, Maryland			
ACTUAL SIGNATURE D. J. Boyer		PHYSICIAN'S NAME (Type) D. J. Boyer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-56	
22c. NAME OF CEMETERY OR CREMATORIAL Eaton Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Young, Jr., Cremation & Burial, Inc., Maryland		24a. REC'D BY REGISTRAR Aug 29, 1956	
24b. REGISTRAR'S SIGNATURE Shane Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RESCUE

BUKEAU V. S.

Aug 31 1956

18721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH ■ COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 44 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 102 Bryan Place		d. STREET ADDRESS 102 Bryan Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George	First	Middle	Last
		William	Bumbaugh
4. DATE OF DEATH Aug. 30 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 15, 1880
9. AGE (In years to last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS Days 15	12. IF UNDER 24 HRS Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. R. Conductor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carlisle, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James William Bumbaugh		14. MOTHER'S MAIDEN NAME Martha Sease	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT 220-16-2386 Mrs. W. George Bumbaugh, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-31-56
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-1-1956	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Maryland
22e. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklyn Rizer	ADDRESS Hagerstown, Maryland	24a. REC'D BY REGISTRAR Sept 3, 1956	24b. REGISTRAR'S SIGNATURE Charles H. Powers

BUREAU V. S

SEP 6 1966

RECEIVED

18722

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 335 W. Washington St.,		e. STREET ADDRESS 335 W. Washington St.,	
3. NAME OF DECEASED (Type or print) George		First I	Middle Childs
4. DATE OF DEATH 8 26 1956	Month 8	Day 26	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1887
9. AGE (In years last birthday) 68 6	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 6	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sold stock	10b. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (State or foreign country) Minnesota	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Job W. Childs		14. MOTHER'S MAIDEN NAME Hannah Jewett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 214-16-0824	17. INFORMANT Howard C Paulin	Address Upland, 578 N. Campus Ave., California
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) -	(County) -	(State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	DATE SIGNED 8-29-56		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-56	22c. NAME OF CEMETERY OR CREMATORIAL Bellevue	22d. LOCATION (City, town, or county) Ontario
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR Sept. 4, 1956
			24b. REGISTRAR'S SIGNATURE Blanche Powers

BUREAU V. S

SEP 6 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8735

CERTIFICATE OF DEATH

Reg. Dist. No.

18723
302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
Washington MARYLAND		Pa.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Blue Ridge Summit Pa.		
Washington County Hospital		d. STREET ADDRESS Fairfield Pa., #1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Viola	Middle Louise	Last Creager	
4. DATE OF DEATH	Month August	Day 10	Year 1956	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 19, 1929	
9. AGE (In years last birthday) 27 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Liberty Township, Adams Co. U.S.A.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Henry Houck	14. MOTHER'S MAIDEN NAME Sarah Forney	Address Fairfield Pa., #1		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT John R. Creager	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Monocytic Leukemia 2042 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	19. INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While pt work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-25-1956, to 8-10-1956, that I last saw the deceased alive on 8-10-1956, and that death occurred at 12:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dalton M. Welty PHYSICIAN'S NAME (Type) Dalton M. Welty, M. D. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 8/11/56	22c. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/56	22c. NAME OF CEMETERY OR CREMATORIAL Harbaugh's	22d. LOCATION (City, town, or county) (State) Smithsburg, Franklin Pa., #2
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Lowe	ADDRESS Waynesboro Pa.	24a. REC'D BY REGISTRAR Reg. 14, 1956	24b. REGISTRAR'S SIGNATURE R. H. St. L. Rivers	

RECEIVED
BUREAU V. S.

JULG 16 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 50 File G202 8-21-56 a.m.

18724

8736

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS Chewsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SIMON	Middle PETER	Last ECCARD	4. DATE OF DEATH August 5	Month 1956	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1885	9. AGE (in years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Mdse.		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Simon P. Eccard		14. MOTHER'S MAIDEN NAME Effie Shuff					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. S. P. Eccard, Chewsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Pulmonary Embolus Spontaneous hip				INTERVAL BETWEEN ONSET AND DEATH 30 min.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING (a) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fall from chair from no apparent reason.		20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Chewsville	
						(County) (State) Md.	
21. I certify that I attended the deceased from 8/5/56 to 8/6/56, 1956, to 8/6/56, 1956, that I last saw the deceased alive on 8/5/56, and that death occurred at 8/6/56, 1956, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>D.J. Boyer</i>		M.D.		ADDRESS (Street, city or town, state) 135 N. Potomac St., Hagerstown, Md.		DATE SIGNED 8/6/56	
PHYSICIAN'S NAME (Type) D.J. Boyer		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Bethel	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>		ADDRESS Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR Aug. 9, 1956		24b. REGISTRAR'S SIGNATURE <i>Frank Boavers</i>	

THE PRACTICAL

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Mr. P. - 2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8737

CERTIFICATE OF DEATH

18725

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 900 Concord Street		
3. NAME OF DECEASED (Type or print) JOHN			First SCOTT	Middle EICHELBERGER	Last Month Day Year August 19 1956
4. DATE OF DEATH	Month August	Day 19	Year 1956	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1876	9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 8 Days 15 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
13. FATHER'S NAME Henry Eichelberger			14. MOTHER'S MAIDEN NAME Louise ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-7414		17. INFORMANT Mrs. Maude Eichelberger	
Address Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 3 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation—Appendectomy, Aug 14, 1956 Appendicitis gangrenous-post-operative					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Place of Injury (Home, farm, factory, street, office bldg., etc.)	(City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 14, 1956, to Aug. 19, 1956, that I last saw the deceased alive on Aug. 18, 1956, and that death occurred at 10:08 A.M. from the causes and on the date stated above. D.S.T. • ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE William T. Layman, M.D.					
PHYSICIAN'S NAME (Type) Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/1956	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Mouzer Funeral Home R. Franklin Ruge		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Aug 22, 1956	24b. REGISTRAR'S SIGNATURE G. H. Bowers

HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AG 11-1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18726
3rd

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Washington MARYLAND		Sharpsburg, Md.		few min.		a. STATE Maryland b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Highway		Sharpsburg Pike & Mechanic Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
						Baltimore		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Lawrence		Odell	Exline		AUG 18			1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY?	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 7, 1922	33 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				
Service Man		C. & P Telephone		Grafton W. Va.		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
Arthur D. Exline			Willa Canfield					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Address		
Yes			Worlard War # 2 234-26-4684			Mrs. Willa Exline - Sharpeburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____								
DUE TO _____								
Conditions, if any, which gave rise to immediate cause (b) _____								
DUE TO _____								
DUE TO (c) _____								
INTERVAL BETWEEN ONSET AND DEATH								
5 min								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
none								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year 1:00 o.m. Aug. 18 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
				Highway		Sharpeburg Wash Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED						
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial		Aug. 21 1956		Mt. View Cemetery		Sharpeburg Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
<i>Albert L. Leaf Williamsport, Md.</i>						<i>E. G. Boyer</i>		
VS. A15ME(5)		DATE		Aug 21 1956				
SM 9/55								

Euclidean V. S

$$SEP = 1500$$

1000
1200
1400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8765

CERTIFICATE OF DEATH

118727
301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE b. COUNTY	
Washington Co. MARYLAND		Pa.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 2 months +	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitorium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle	
3. NAME OF DECEASED (Type or print) Margaret		First R.	Middle Fletcher
4. DATE OF DEATH August 26, 1956		Lost	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14 1880
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher & Principle		9. AGE (in years lost birthday) 76 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greencastle, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles F. Fletcher		14. MOTHER'S MAIDEN NAME Margaret Ruthruff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Harry Grove - greencastle, Pa.		Address 204 5th Washington St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease		2 months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to August 26, 1956, that I last saw the deceased alive on Aug 25, 1956, and that death occurred at 11:45 a.m. from the causes and on the date stated above			
ACTUAL SIGNATURE Paul H. Haak, M.D.		ADDRESS (Street, city or town, state) Williamsport, Md 26 Aug 56	
PHYSICIAN'S NAME (Type) Paul H. Haak, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/56	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.		22d. LOCATION (City, town, or county) Greencastle, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Minnick		ADDRESS Greencastle, Pa.	
24a. REC'D BY REGISTRAR E. Le Neve		24b. REGISTRAR'S SIGNATURE Aug. 28 1956	

BUREAU Y. S.

AUG 30 1956

RECEIVED

PR. S. FARR, YOUNG
 148 N. POTOMAC ST
 HAGERSTOWN, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8738

CERTIFICATE OF DEATH

118728
 302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERS TOWN		c. LENGTH OF STAY IN 1b 7 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN		d. STREET ADDRESS 36 CEMETERY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARGARET VIOLA FORREST		First	Middle	Loss	4. DATE OF DEATH AUGUST - 23 - 1956	Month	Day	Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MARCH - 2 - 1889	9. AGE (in years last birthday) 67-5-21	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) SMITHSBURG, WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME JOSEPH H. RUDISILL		14. MOTHER'S MAIDEN NAME ELVA PAPER		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT OMER E. FORREST FUNKSTOWN MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8121, 1956, to 8123, 1956		20f. (City or town) 650A		(County)	(State)	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Boonsboro MD								
ACTUAL TIME		DATE SIGNED 8/24/56								
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 25, 1956		22c. NAME OF CEMETERY OR CREMATORIAL LUTHERAN CEMETERY		22d. LOCATION (City, town, or county) MIDDLETOWN FRED. CO. MD.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE BEST FUNERAL HOME Boonsboro MD		ADDRESS Aug. 28, 1956 Joseph Bowers								
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE								

1956

AUG 30 1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8765

CERTIFICATE OF DEATH

68729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md RFD #1		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Maryland RFD #1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Maryland RFD #1	
3. NAME OF DECEASED (Type or print) George William Fowler		4. DATE OF DEATH August 31 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Downsville Md Dist.
13. FATHER'S NAME Noah Fowler		14. MOTHER'S MAIDEN NAME Mary Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Viola Bowers		Address Williamsport Maryland RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fire DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/30/56, 19, to 8/31/56 19, that I last saw the deceased alive on 8/30/56, 19, and that death occurred on 8/31/56, 19, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <i>Albert G. Young</i> ACTUAL SIGNATURE <i>Albert G. Young</i> DATE SIGNED <i>8/31/56</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2-56	
22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		22d. LOCATION (City, town, or county) Near Clearspring (State) Western Pike Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert G. Young Williamsport Md</i>		24a. REC'D BY REGISTRAR DATE <i>Sept 2-56</i>	
		24b. REGISTRAR'S SIGNATURE <i>John P. Gray</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000-1000

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1000-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr E. V. Ditto

18730

8767

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R. # 3		c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R. # 6		d. STREET ADDRESS Laugansville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Conv. Home				d. STREET ADDRESS Laugansville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First ELLEN		Last GELTLACHER		4. DATE OF DEATH August 12 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 19 1880	
9. AGE (In years lost birthday) 76 yrs		10. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Own Home		12. CITIZEN OF WHAT COUNTRY? Welsh Run Pa USA	
13. FATHER'S NAME Abraham Keadle		14. MOTHER'S MAIDEN NAME Kate Hose					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT George H. Keadle		Address Hagerstown Md. P. # 6	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO Arterio Thrombosis Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1-1936 to 8-12-1956, that I last saw the deceased alive on 6-1-1936, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. E. V. Ditto PHYSICIAN'S NAME (Type) Hagerstown Md. 8-12-1956						ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/56		22c. NAME OF CEMETERY OR CREMATORIUM Bunkard Cemetery		22d. LOCATION (City, town, or county) Broadfording Wash Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hs., Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Aug 15:56 Leroy M. Zwickler		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

BUREAU V. 2

Aug 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8739 CERTIFICATE OF DEATH										18731, Weeks	
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland					Reg. Dist. No. 3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 5 Min.			b. COUNTY Washington						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. STREET ADDRESS 51 East Ervin Ave			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown						
3. NAME OF DECEASED (Type or print)		First Leha	Middle Marzalia	Last Glenn	4. DATE OF DEATH August		Month 19	Day 19	Year 1956	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1873		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Gimple					14. MOTHER'S MAIDEN NAME Margaret Rhodenizer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. L. S. Potti 51 E. Irvin Ave			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypox					19. INTERVAL BETWEEN ONSET AND DEATH Hagerstown - u. but many irregularities & symptoms in between						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Anoxia					(c)						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anoxia										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Anoxia									
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County)		(State)		
21. I certify that I attended the deceased from <u>August 6, 1956</u> to <u>August 19, 1956</u> that I last saw the deceased alive on <u>August 10, 1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE Howard N. Weeks, M.D.		ADDRESS (Street, city or town, state) 136 N. Potomac St., Hagerstown, Maryland								DATE SIGNED 8/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/56	22c. NAME OF CEMETERY OR CREMATORIUM Funkstown Cemetery		22d. LOCATION (City, town, or county) Funkstown, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew C. Coffin, Jr., F. P. T. M. d.		24a. REC'D BY REGISTRAR Aug. 24, 1956								24b. REGISTRAR'S SIGNATURE B. H. Bowers	

Q. 1

22

MARYLAND STATE DEPARTMENT OF HEALTH

88732

8768

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY TOWN STREET ADDRESS		Maryland Washington			
		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Hancock		LENGTH OF STAY (In this place) Accident		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Hagerstown			
3. NAME OF DECEASED (Type or Print)		(First) John (Middle) Curtis (Last) Grove		4. DATE OF DEATH		(Month) 8	(Day) 4	(Year) 56 19	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
Male		W.		Married		11.1.1919		36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
Sheet and Lott		Craft		Washington Md		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Charles Curtis Grove		Lettie V Keefer							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION			
No		220-69-7293		Mrs Cora V Grove Rural 2 Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Fractured skull		10 min			
Immediate cause		(a)							
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		(b)		Multiple fractures lower extremities Haemorrhage & shock					
(c)									
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?			
None						Yes <input type="checkbox"/> No <input type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.									
SIGNATURE S. Robert Heller, M.D.		DEPUTY (Degree or title) WASH. D.C.		ADDRESS Hagerstown, Md.		DATE SIGNED Aug. 5 1956			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 8.8.56		NAME OF CEMETERY OR CREMATORIUM Park Head Cemetery		LOCATION (City, town, or county) Hancock Md Washington Md (State)			
DATE REC'D BY LOCAL REG. Aug. 1956		REG.		24. FUNERAL DIRECTOR Howard F. Stone Hancock Md		ADDRESS			
REG.		REG.		REG.		REG.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 10 36

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8769

CERTIFICATE OF DEATH

Reg. Dist. No.

68733
303

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BIG POOL		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BIG POOL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHANKTOWN ROAD		d. STREET ADDRESS SHANKTOWN ROAD	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle ELIZABETH	Last HASTINGS
4. DATE OF DEATH 8	Month Month	Day 13	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV, 23, 1880
9. AGE (in years last birthday) 75	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
13. FATHER'S NAME SAMUEL PENNER	14. MOTHER'S MAIDEN NAME LOUISE MILLER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. GARRET SHANK BIG POOL RT 1 MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 14</u> , 1956, to <u>August 13, 1956</u> , that I last saw the deceased alive on <u>August 11</u> , 1956, and that death occurred at <u>8:30 pm</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Archie Robert Cohen	M.D.		
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	Clear Spring, Md. 8/13/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/15/56	22c. NAME OF CEMETERY OR CREMATORIAL ST. PAULS	22d. LOCATION (City, town, or county) CLEAR SPRING MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark	ADDRESS Clear Spring, Md.	24a. REC'D BY REGISTRAR DATE Aug 15-56	24b. REGISTRAR'S SIGNATURE Josephus Murray

MEAU A. S.

1956 20 09

REGISTRY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8740 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 168734

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 230 Summit Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First RALPH	Middle N	Last HAUPT	4. DATE OF DEATH Month August Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Northumberland Co. Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Jerome Haupt		
14. MOTHER'S MAIDEN NAME FLORA First name unknown, last name DITTY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 205-09-6614 17. INFORMANT Mrs. Ralph N. Haupt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			Address 230 Summit Ave. Hagerstown, Md.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic coronary heart disease DUE TO acute coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) Hagerstown		(County) Washington		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE S. R. Wells		DATE SIGNED 8-11-56			
EXAMINER'S NAME (Type) S. R. Wells M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/56		22c. NAME OF CEMETERY OR CREMATORIAL REST Haven Cemetery	
22d. LOCATION (City, town, or county) Hagerstown		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel, Inc. Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Date Aug. 13, 1956	
				24b. REGISTRAR'S SIGNATURE Chas. H. Powers	

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1970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8741

CERTIFICATE OF DEATH

Mr. Ralph Young

Reg. Dist. No.

68735

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY	
Anne Arundel		Maryland		Anne Arundel		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 1 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Baltimore				Hagerstown		310 E. Commonwealth	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
St. Luke's Hospital							
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year
FREDERICK		ALLEN	HENRY	August 26	1959		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min
M		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 23 1930	29		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Waiter		Infant		Maryland		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
W.L. Henry		Johns Stull					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		John Henry			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Double Sulfapyridine & Double Sulfamerazine DUE TO: Congenital Malformation of Bladder & recto- esophageal fistula & recto- esophageal fistula & congenital hyperplasia of prostate							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) & (c)							
DUE TO: Congenital Malformation of Bladder & recto- esophageal fistula & recto- esophageal fistula & congenital hyperplasia of prostate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19				Hagerstown		Hagerstown	
21. I certify that I attended the deceased from <u>Sept. 1</u> , 19 <u>59</u> , to <u>Sept. 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 1</u> , 19 <u>59</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Ralph Young</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		Aug. 27, 1959		St. Luke's Cemetery		Hagerstown	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John H. Bowers				Aug. 29, 1959		John H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

Aug 11 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18736

8770

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington MARYLAND		Penns. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Carfoss, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Greencastle	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown Route 4		d. STREET ADDRESS Greencastle RD 2, Pa.	
3. NAME OF DECEASED (Type or print) ELMER CLAYTON		First	Middle
		Last	4. DATE OF DEATH
		HOFFMAN	August
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		white	b. DATE OF BIRTH Aug. 30, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Mt. Lena, Md.
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Henry Hoffman		Amanda Houpt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT	
		Charles E. Hoffman	
		Address RD 4 Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
44dx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Co-heroselerosis. Cardiovascular renal disease 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/1939 to 8/1/1956, that I last saw the deceased alive on 8/1/1956, and that death occurred at 6:25 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Greencastle, Pa. DATE SIGNED 8/2/56	
ACTUAL SIGNATURE W. C. BREWER		NAME (Type) W. C. BREWER	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/56	
22c. NAME OF CEMETERY OR CREMATORIAL Salem Reformed		22d. LOCATION (City, town, or county) Carfoss, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. Mennich		ADDRESS Greencastle, Pa.	
24a. REC'D BY REGISTRAR Aug. 3, 1956		24b. REGISTRAR'S SIGNATURE W. C. BREWER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUXTON Y. S

JUG 5 1956

REGREV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118737

8771

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boonsboro		c. LENGTH OF STAY IN 1b 12 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. MAIN ST.		d. STREET ADDRESS N. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle C	Last HOUCK	4. DATE OF DEATH AUGUST - 26 - 1956	Month AUGUST	Day 26	Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29 1879	9. AGE (In years lost birthday) 77 029	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED. MINE OPERATOR - COAL		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME DANIEL HOUCK		14. MOTHER'S MAIDEN NAME MARY ANTHONY		Address Boonsboro MD.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 219-03-8324		17. INFORMANT MRS. LULA HOUCK		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cholecystitis DUE TO Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) _____		19. INTERVAL BETWEEN ONSET AND DEATH 1 Yr. 91. 26		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro	20f. (City or town) Boonsboro	(County) Washington Co.	(State) Md.
21. I certify that I attended the deceased from Nov. 20, 1954 to Aug. 26, 1956 that I last saw the deceased alive on Aug. 26, 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro, Md.		DATE SIGNED 8-28-56		ACTUAL SIGNATURE J. Hubert Wade, M.D.		FIRMED NAME (Type) J. Hubert Wade, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 29, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Boonsboro CEMETERY	22d. LOCATION (City, town, or county) Boonsboro WASH. CO. MD.							
23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME Boonsboro MD		ADDRESS Boonsboro MD	24a. REC'D BY REGISTRAR Aug. 28, 1956	24b. REGISTRAR'S SIGNATURE John H. Bast						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUNNELL LIBRARY

AUG 30 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8772 8738

8772

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md. RFD		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 81 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md. RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Antietam		d. STREET ADDRESS Antietam Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Washington Hutson	First	Middle	Last
4. DATE OF DEATH Aug. 10 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24 1875
9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 16	12. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY General Work	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hutson		14. MOTHER'S MAIDEN NAME Mary L. Lock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (If yes, give war or dates of service) 2nd		16. SOCIAL SECURITY NO. 215-42-116	
17. INFORMANT Mr. James E. Hutson		Address Antietam Sharpsburg Md. RFD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cardio-vascular-renal arteriosclerotic (c) disease.		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Solid tumor of the testicle - probably sarcoma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1950 to August 10 1956, that I last saw the deceased alive on 8/9/56, 19, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL Sharpsburg, Md. DATE SIGNED 8/11/56			
PHYSICIAN'S NAME (Type) Walter N. Shealy M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 13, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery		22d. LOCATION (City, town, or county) Sharpsburg Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf		24a. REC'D BY REGISTRAR DATE Aug. 14, 1956	
		24b. REGISTRAR'S SIGNATURE E. G. Boyer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION

AUG 20 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISM(E)5
5M 9/55

10739

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sharpsburg, Md.		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,	
f. STREET ADDRESS 41 Fairground Ave		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence		First Junior	Middle Karn
4. DATE OF DEATH August 25 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1933
9. AGE (in years last birthday) 23 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Community Cab Co.	
11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence H. Karn		14. MOTHER'S MAIDEN NAME Sarah E. Rohrer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-28-2950	
17. INFORMANT Mrs. Mary Netz Karn - 41 Fairground Ave		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull (closed)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Fractured Jaw (closed)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Depressed fractured sternum (closed)			
DUE TO Hemorrhage & shock			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Driver of automobile that hit tree when he failed to negotiate a curve.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 12:45 a. m. Aug. 25 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Rural - Sharpsburg, Wash., Md.		(County) Rural - Sharpsburg, Wash., Md.	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	DATE SIGNED Aug. 27 1956		
EXAMINER'S NAME (Type) S. Robert Wells, M. D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 28 1956	22c. NAME OF CEMETERY OR CREMATORIAL Boonsboro	22d. LOCATION (City, town, or county) Boonsboro, Wash., Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Carl Paul Horne</i>	ADDRESS Boonsboro, Md.	24a. REC'D BY REGISTRAR 1/4/56	24b. REGISTRAR'S SIGNATURE <i>Elmer Bayes</i>

3. A. 800000

1951 - 1952

1951-1952

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V5. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8774 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Items 3, 7, 16 Film G202 8-30-56 et

68740
 Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - US # 40		c. LENGTH OF STAY IN 1b None		c. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frostburg- Clarysville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown, Maryland			d. STREET ADDRESS R # 2		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Stanley		First Middle Martin	LaRue	4. DATE OF DEATH Month August Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1921	9. AGE (in years last birthday) 3 5 yrs.	10. FUNDER 1YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Motor Truck Co.		11. BIRTHPLACE (State or foreign country) Garrett County, Md.	
13. FATHER'S NAME Martin LaRue			14. MOTHER'S MAIDEN NAME Margaret Burdock		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W W W 2 213-12-9015		17. INFORMANT Address Mrs. Edna D. LaRue - R # 1- Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Sternum</u>					
DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Contusion & hemorrhage into heart</u>					
DUE TO (a), stating the underlying cause (c) <u>auricular muscle (Shock)</u>					
10 min					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
None					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Hour 3:00 P.M. Aug. 24 56		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor-Trailer collision			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Rural- Hagerstown, Wash Md		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-24-56	
NAME (Type) S. Robert Wells, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-56		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg, Md.	
22d. LOCATION (City, town, or county) Frostburg Allegany Co. Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew Coffman		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 8/28/56	
24b. REGISTRAR'S SIGNATURE <i>Joseph W. Murray</i>					

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8775

CERTIFICATE OF DEATH

18741
Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 9 WEEKS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REFUGER NURSING HOME		d. STREET ADDRESS 326 NORTH MAIN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EFFIE M. LIGHTER		First	Middle
4. DATE OF DEATH AUGUST - 31 - 1956		Month	Day
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT-11-1872
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 83-11-20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NB. MIDDLETON TRED CO. MP. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PETER J. BRANDENBURG		14. MOTHER'S MAIDEN NAME CATHERINE FLOOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NON/E	
17. INFORMANT DENVER S. WYAND Boonsboro WASH. CO. MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 7 Mo. 29 Day	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 2 , 1956, to Aug. 31 , 1956, that I last saw the deceased alive on Aug. 27 , 1956, and that death occurred at 30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Hubert Wade.</i>		ADDRESS (Street, city or town, state) Boonsboro, Maryland	
PHYSICIAN'S NAME (Type) J. Hubert Wade, M. D.		DATE SIGNED 9-1-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 2, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Boonsboro CEMETERY
23. FUNERAL DIRECTOR'S SIGNATURE Best FUNERAL HOME		ADDRESS Boonsboro MD.	24a. REC'D BY REGISTRAR DATE 9-2-56
			24b. REGISTRAR'S SIGNATURE John H. Best

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.
REGELVING

SEP 5 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8776

CERTIFICATE OF DEATH

68742
383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. RFD #2		c. LENGTH OF STAY IN 1b 2 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Huyett's Crossroads		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LAURA		First Middle Last	4. DATE OF DEATH Aug. 26 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 13 1871			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Texas			
13. FATHER'S NAME (First Unknown) Stansbury		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Issac Ward Hagerstown Md. RFD #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Generalized advanced arteriosclerosis Arteriosclerotic myocardial heart disease with myocardial failure grade iv chr glomerular nephritis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. nono 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from Sept. 1945 to Aug. 26 1956, that I last saw the deceased alive on Aug. 7 1956, and that death occurred on Aug. 30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE S. Robert Wells		ADDRESS (Street, city or town, state) M.D. 115 N. Potomac Street		DATE SIGNED 8-28-56		
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30-56	22c. NAME OF CEMETERY OR CREMATORIUM Broadfording Cemetery	22d. LOCATION (City, town, or county) Broadfording	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Teof		ADDRESS Williamsport, Md.	24a. REC'D BY REGISTRAR Aug. 30-56	24b. REGISTRAR'S SIGNATURE Loring M. Tolles		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

SEP 6 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Ralph Young

68743

8742

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 1				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS Dual Highway		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CATHERINE		First	Middle	Lost	4. DATE OF DEATH August 16	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 14 1956	9. AGE (In years lost birthday) yrs. 3	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wm Luther Miley		14. MOTHER'S MAIDEN NAME Dorothy Lee Ruck		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT W.L. Miley Hagerstown Md. R # 1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)
21. I certify that I attended the deceased from <u>8/14/56</u> , 19 <u>56</u> , to <u>8/16/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/14/56</u> , 19 <u>56</u> , and that death occurred at <u>Hagerstown</u> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state)								DATE SIGNED
ACTUAL SIGNATURE Ralph Young M.D.		PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/56		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Anarey A. Cofflin Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Aug. 18, 1956		24b. REGISTRAR'S SIGNATURE Joseph Powers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CREAU V. S

AUG 22 1995

CREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8743

CERTIFICATE OF DEATH

18744

302

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: Title law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. SHEALY

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 24 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. CARMEL - RURAL		d. STREET ADDRESS BOONSBORO MD. R. 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				d. STREET ADDRESS BOONSBORO MD. R. 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE OLIN		First	Middle	Last	4. DATE OF DEATH Month AUGUST 26, 1956	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 29, 1888	9. AGE (In years lost birthday) 67-7-27	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY GINN FARM		11. BIRTHPLACE (State or foreign country) MT. CARMEL WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME OTHO J. MILLER		14. MOTHER'S MAIDEN NAME FLORENCE BISER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-36-4890	
				17. INFORMANT MRS. BESSE MILLER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic uremic colitis	
						INTERVAL BETWEEN ONSET AND DEATH 3 days	
		DUE TO Uremia				10 days	
		DUE TO Cardio-vascular-renal disease				3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic heart disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from about 1950, 19 to 8/26 1956 that I last saw the deceased alive on 8/26/56 , 19, and that death occurred at 12:01 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Sharpsburg, Md.	
						DATE SIGNED 8/28/56	
MEDICAL CERTIFICATION NOTARY SIGNATURE Walter H. Shealy							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 30, 1956		22c. NAME OF CEMETERY OR CREMATORIAL BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BEST FINE 24 - Home		ADDRESS Boonsboro MD.		24a. REC'D BY REGISTRAR Aug. 30, 1956		24b. REGISTRAR'S SIGNATURE Walter H. Shealy	

MEAU A. S

SEP 4 1966

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111 3

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8777

CERTIFICATE OF DEATH

Reg. Dist. No. 18745

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilson District	c. LENGTH OF STAY IN 1b 6 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pinesburg Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS Pinesburg Maryland	
3. NAME OF DECEASED (Type or print) Charles Edward Mulligan		4. DATE OF DEATH Aug. 17 1956	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Farm		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Pete Mulligan	
14. MOTHER'S MAIDEN NAME Sarah Grove		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No No None	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Daniel Mulligan 27 ^{11th} Westside Ave. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
Carcinoma of stomach			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 15, 1956, to Aug 17, 1956, that I last saw the deceased alive on Aug 16, 1956, and that death occurred at 7:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>David R. Brewer</i> M.D. ADDRESS (Street, city or town, state) <i>Clear Spring</i> DATE SIGNED <i>8/17/56</i> PHYSICIAN'S NAME (Type) <i>David R. Brewer</i> MD!			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20-56	22c. NAME OF CEMETERY OR CREMATORIAL Mennoite Cemetery
22d. LOCATION (City, town, or county) Pinesburg		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edith V. Leaf</i>		24a. REC'D BY REGISTRAR DATE Aug 20-56	24b. REGISTRAR'S SIGNATURE <i>Leroy M. Franklin</i>

CLAU V. S

AUG 21 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. (Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSMES(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8744 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302	68746		
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Convalescent Home					d. STREET ADDRESS 342 N. Potomac Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HELEN		First LUCRETIA		Middle MUNDEY		4. DATE OF DEATH August 26 1956							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 20, 1866		9. AGE (in years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 3 Days 6 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Gossard					14. MOTHER'S MAIDEN NAME ? Fales								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Roy L. Mundey		Address Hagerstown, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced generalized arteriosclerosis DUE TO arteriosclerotic heart disease with failure grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Dementia										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none											
20c. TIME OF INJURY Hour a. m. p. m. none		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) —		(County) —		(State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 8-27-56			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/1956		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home <i>P. Franklin Rouzer</i>										24a. REC'D BY REGISTRAR Aug. 30, 1956			
										24b. REGISTRAR'S SIGNATURE <i>W. H. St. Gowers</i>			

BL-200 V. 2

SEP 4 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8745 CERTIFICATE OF DEATH

Reg. Dist. No. 18747
302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 548 George Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PEGGY	Middle ANN	Last MYERS	4. DATE OF DEATH August 19, 1956	Month August	Day 1	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 19, 1956	9. AGE (In years last birthday) yrs. Months	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Myers				14. MOTHER'S MAIDEN NAME Dorothy Mc Carney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT none		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Erythroblastosis fetalis</i> DUE TO <i>470.0</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>atalectasis</i> DUE TO <i>12 hours</i> (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>atalectasis</i> 19. WAS AUTOB ^Y PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>8/10/56</i> , 1956, to <i>8/11/56</i> , 1956, that I last saw the deceased alive on <i>8/11/56</i> , 1956, and that death occurred at <i>9:35 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Hagerstown, Maryland</i> DATE SIGNED <i>8/13/56</i>							
ACTUAL SIGNATURE <i>A. M. Bacon Jr.</i> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			22d. LOCATION (City, town, or county) Hagerstown, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Franklin Jr.</i>		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR Aug. 13, 1956		24b. REGISTRAR'S SIGNATURE <i>John R. Franklin Jr.</i>	

BLREAU V. S.

Aug 24 1955

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8746

CERTIFICATE OF DEATH

18748
302
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
				b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Hagerstown 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				Cullen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington County Hospital		d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First John	Middle R.	Last Naylor	4. DATE OF DEATH August 11, 1956
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 24, 1877	9. AGE (In years last birthday) 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waynesboro Pa.	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. H. Naylor		14. MOTHER'S MAIDEN NAME Edith Wagaman		Address Lowell Naylor, Cullen Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT	
				L	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Pyelonephritis DUE TO (c)		Two Weeks			
		One Week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) — (County) (State)	
21. I certify that I attended the deceased from alive on 8/11, 1956		19 56, to 8/11, 1956, that I last saw the deceased and that death occurred at 9:25 A.M. from the causes and on the date stated above.			
SIGNATURE J. G. Warden, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)		832 Potomac Ave, Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 307-71		22b. DATE THEREOF 8/14/56		22c. NAME OF CEMETERY OR CREMATORIAL St. Jacobs	
22d. LOCATION (City, town, or county) (State)		Fairfield, Adams Pa., #1			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR 18/14/1956	
				24b. REGISTRAR'S SIGNATURE	

1 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88749

8747

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 142 roadway		d. STREET ADDRESS 142 roadway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary	First	Middle	4. DATE OF DEATH Aug. 25 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-1877
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Augustus Niceman		14. MOTHER'S MAIDEN NAME Philomena Speckman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT William C. Nehring, Hagerstown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic gangrene of left foot		INTERVAL BETWEEN ONSET AND DEATH 6 months	
450.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Generalized arteriosclerosis		years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoarthritis for 19 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Summer</u> , 19 <u>57</u> , to <u>August 25 1956</u> , that I last saw the deceased alive on <u>August 21 1956</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>R. A. Bell</u>		ADDRESS (Street, city or town, state) 119 North Potomac Street, Hagerstown, Maryland DATE SIGNED 8-27-56	
PHYSICIAN'S NAME (Type) R. A. Bell		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-28-1956	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Berger		ADDRESS Hagerstown, Maryland	
		24a. REC'D BY REGISTRAR Aug. 30 1956	
		24b. REGISTRAR'S SIGNATURE B. H. Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by
 page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED BY: *[Signature]*

SEP 4 1966

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8778

CERTIFICATE OF DEATH

18750

Reg. Dist. No. 392 307

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown-Rural-R.D.#2		c. LENGTH OF STAY IN 1b Since 1951		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Irvington		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DAISY	Middle VICTORIA	Last NINER	4. DATE OF DEATH	Month Aug	Day 18	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1879	9. AGE (in years last birthday 77)	F. UNDER 1 YEAR Months 6	F. UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ USA	
13. FATHER'S NAME Silas L. Rickerd				14. MOTHER'S MAIDEN NAME Mary Hart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Luther Mahoney, 610 Military Road, Frederick, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Carcinoma of Throat (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Clear Spring	(County) Maryland
21. I certify that I attended the deceased from April 7, 1956 , to Aug 18, 1956 , that I last saw the deceased alive on Aug 17, 1956 , and that death occurred at 610 Military , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clear Spring, Md.							
ACTUAL SIGNATURE <i>David R. Brewer</i>	M.D.						DATE/SIGNED Aug 21, 1956
PHYSICIAN'S NAME (Type) Dr. David R. Brewer	Same as above						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 21, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	24a. REC'D. BY REGISTRAR Aug 21, 1956		24b. REGISTRAR'S SIGNATURE Chas. Bowes		

BUREAU V. 3

AUG 21 1956

REGISTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VIA AIR (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
 8779 CERTIFICATE OF DEATH

118751

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTNUT GROVE - RURAL		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 37 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTNUT GROVE - RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DR. LEYAN		d. STREET ADDRESS KEEDYSVILLE MD. P.I.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LLOYD CLEVELAND NORFORD		First L	Middle C
4. DATE OF DEATH Month AUGUST	Day 2	Year 1956	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JANUARY 22 1885 71-670
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) ALBERMARLE CO. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD NORFORD		14. MOTHER'S MAIDEN NAME ESSIE NEWMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. NONIE	
17. INFORMANT MRS. ESSIE NORFORD		Address KEEDYSVILLE MD. P.I.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 34 hrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 31, 1956 to Aug. 2, 1956 that I last saw the deceased alive on August 1, 1956 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. Lekam M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1956	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BOONS BORO CEMETERY BOONS BORO WASH CO. MD.
22d. LOCATION (City, town, or county) (State)		22e. REG'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE DATE Aug. 7-1956 Mrs. Katherine Daguerhart	
23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME		24. ADDRESS BOONS BORO MD.	

RECEIVED
BUREAU V. S.

AUG 9 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

18752

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8748 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R # 1 - Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS R # 1 - rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Edward		First James	Middle Pearman	Last	4. DATE OF DEATH Month Aug. Day 9 Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11 1986		9. AGE (In years month/ day) 70 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired broommaker		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Warren - Pearman			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-6338		17. INFORMANT Address 7 S. Vermont Edward J. Pearman, Jr- Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture lower rt tibia & fibula DUE TO Chirrhosis of liver INTERVAL BETWEEN ONSET AND DEATH 21 days 1.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Acute Cerebral hemorrhage DUE TO alcoholism 4 hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) alcoholism					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off step ladder while painting at home			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. July 19 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home 20f. (City or town) Williamsport, Wash. Md. (County) Williamsport (State) Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>S. Robert Wells, M.D.</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-10-56 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-56		22c. NAME OF CEMETERY OR CREMATORIAL Greenbriar 22d. LOCATION (City, town, or county) Williamsport- Wash- Md. (State) Wash. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert Leaf</i>			ADDRESS Albert Leaf - Williamsport, Md. 24a. REC'D BY REGISTRAR Aug. 14, 1956 24b. REGISTRAR'S SIGNATURE <i>Joseph H. Powers</i>		

BUREAU V. 51

AUG 16 1956

RECEIVED

68754

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8780

Reg. Dist. No.

305

TO DEATH MEDICINE: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/transit, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington MARYLAND		Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None - Main Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville- Rural	
d. STREET ADDRESS R # 1 Keedysville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First	Middle
Last		4. DATE OF DEATH	Month Day Year
Remsburg		August 4	1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	July 29, 1888	9. AGE (In years last birthday) 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Stock Dealer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Sharpsburg- Wash Co.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME C. Hicks Remsburg		14. MOTHER'S MAIDEN NAME Alice D. Nicodemus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Olive Remsburg - R # 1 Keedysville, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic myocradial heart disease with myocardial failure- grade iv 2 yr	
DUE TO			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)		Rheumatic Heart disease 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
		20f. (City or town) -	(County) (State) - - -
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED 8-6-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-56	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mountain View Cemetery
22d. LOCATION (City, town, or county) Sharpsburg, Wash Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bast Funeral Home - Boonsboro, Maryland		24b. REC'D BY REGISTRAR DATE (Aug. 6, 1956)	24b. REGISTRAR'S SIGNATURE <i>Julia H. Bast</i>

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8749

CERTIFICATE OF DEATH

Reg. Dist. No.

302

118755

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission) a. STATE Md. b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 1016 Mulberry Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Paul	Middle Edward	Last Rider	4. DATE OF DEATH August 16	Month Year 1956
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1900	9. AGE (in years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) staff Mgr.			10b. KIND OF BUSINESS OR INDUSTRY insurance Co.	11. BIRTHPLACE (State or foreign country) Berkley Springs, W. Va.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward A. Rider			14. MOTHER'S MAIDEN NAME Sarah Payne		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Pearl Rider, Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.			Month 19	Day 16	Year 1956
20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Aug 16, 1956</u> to <u>Aug 16, 1956</u> that I last saw the deceased alive on <u>Aug 16, 1956</u> , and that death occurred at <u>7:30 AM</u> on the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE 			M.D. 221 W. WASHINGTON ST., HAGERSTOWN, MARYLAND.		
PHYSICIAN'S NAME (Type) J. H. BEACHLEY, M. D.			8/17/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-18-56	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.			ADDRESS	24a. REC'D BY REGISTRAR Aug. 18, 1956	24b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-train permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CAU V. 2

113 1956

REVIE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68756

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
Washington MARYLAND		a. STATE	Maryland Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Brownsville	1 yr	Brownsville						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at home				d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
David		Henry		Roelkey	3rd	Aug.	18	19 56
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-30-18	38 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Conductor		B. & O Railroad		Knoxville, Md.		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
David H. Roelkey, Jr.				Helen Hightman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes W. W. II		710-07-680		David H. Roelkey, Jr. Knoxville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
DUE TO Gun shot thru skull into brain								
INTERVAL BETWEEN ONSET AND DEATH mins.								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self after having shot wife with a .32 calibre revolver								
20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
11:30 m.	Aug. 18 '56		Home	Brownsville	Wash.	Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE	S. Robert Wells, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			8-20-56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)				
Burial	8-21-1956	Mt. Olivet Cemetery	Frederick	Md.				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. ECD BY REGISTRAR	24b. REGISTRAR'S SIGNATURE				
Gladhill C. Middlebrook, Md.			Aug 22-1956	Miss Katherine Dagerhart				

ALLEGRA V. K.

UG 03 1956

ALLEGRA V. K.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8757

8782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 307

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word 'pending', in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownsville		c. LENGTH OF STAY IN 1b 1 yr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eleanor	First Eleanor	Middle Ada	Last Roelkey
4. DATE OF DEATH Aug. 18 1956	Month Aug.	Day 18	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1924
9. AGE (In years last birthday) 32 yrs.	10. IF UNDER 1 YEAR Months 32	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY House work	11. BIRTHPLACE (State or foreign country) Watertown, N. Y.	
13. FATHER'S NAME Leslie Holkins		14. MOTHER'S MAIDEN NAME Lois Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Lesley Holkins, Phila., N. Y.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. - (b) DUE TO (c)			
Gun shot thru skull into brain mins.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I(a)			
None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 11:10 a.m. Aug. 18 1956		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by husband with .32 calibre revolver	
20c. TIME OF INJURY Hour 11:10	Month, Day, Year Aug. 18 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, offce bldg., etc.) Home
20f. (City or town) Brownsville		(County) Wash	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	DATE SIGNED 8-20-56		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-25-1956	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Philadelphia Cemetery	22d. LOCATION (City, town, or county) Philadelphia Jefferson Co. N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Baptist Funeral Home		24a. REC'D BY REGISTRAR Aug 21 1956	
		24b. REGISTRAR'S SIGNATURE Mrs. Katherine Dagenhart	

RECEIVED
BIRNEY V. S.

AUG 22 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8750 CERTIFICATE OF DEATH

118758-302
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown

c. LENGTH OF STAY IN lb 3 WKS

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna b. COUNTY Franklin

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle

d. STREET ADDRESS 101 West Baltimore St

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
Fred Stanley Shankhoffz August 5, 1956

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED Widowed Divorced 8. DATE OF BIRTH 8/17/1915 9. AGE (In years, last birthday) 41 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Maker

10b. KIND OF BUSINESS OR INDUSTRY SKF: Mechanics

11. BIRTHPLACE (State or foreign country) Franklin Co. Penna

12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME O. C. Shankhoffz 14. MOTHER'S MAIDEN NAME Mary Overhunk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? No 16. SOCIAL SECURITY NO 17. INFORMANT Mr. O. C. Shankhoffz, Greencastle, Pa Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO CEREBRAL HEMORRHAGE INTERVAL BETWEEN ONSET AND DEATH 2-425
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO MALIGNANT HYPERTENSION 10 years
(c) DUE TO CHRONIC GLOMERULO-NEPHROSIS 10-15 yrs

19. WAS AUTOPSY PERFORMED? YES NO

20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a. m. 19 While at work Not while at work

p. m.

21. I certify that I attended the deceased from July, 1956, to Aug. 1956, that I last saw the deceased alive on 7 Aug 56, 1956, and that death occurred at Greencastle, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE B. W. Webster M.D.

PHYSICIAN'S NAME (Type) P. F. Webster M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State)
Burial 8/7/1956 Cedar Hill Cemetery Greencastle, Franklin, Penna

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
Donald M. Zimmerman Greencastle, Pa Aug 8 1956 Frank Bowers

VS A15 (4)
15M 9/55

BUREAU V. S.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68759

Reg. Dist. No. 302

8751

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the register prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 40 min.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS Md. Hotel - 106 W. Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George		First Middle George Daniel		Last Shubert		4. DATE OF DEATH August 12	Month	Day	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 14, 1889	9. AGE (in years from birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John M. Shubert		14. MOTHER'S MAIDEN NAME Anna Elizabeth Bowman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1 214-14-6068		17. INFORMANT Mildred Sprecher - R # 4 Hagerstown, Md.		Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		
DUE TO <u>Acute myocardial dilatation</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>None</u>		
DUE TO <u>(c)</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
none		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL SIGNATURE <u>S. Robert Wells, M.D.</u>	DATE SIGNED 8-14-56			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 15, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.	ADDRESS Wm. A. Stark J. P. Ross	24a. RECD BY REGISTRAR Aug. 15, 1956	24b. REGISTRAR'S SIGNATURE L. H. Bassett, Esq.	

RECEIVED

AUG 17 1966

BUFFALO N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8783

CERTIFICATE OF DEATH

08760

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown RFD		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Terrey Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) ANNA MAY SMITH		d. STREET ADDRESS 1016 Oxford Circle	
5. SEX Female		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH Oct. 29, 1860	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 73 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Huyetts, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Lefever		14. MOTHER'S MAIDEN NAME Rebecca Hose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Lloyd L. Smith-Clearspring, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of Pubic Bone DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTR BUT NOT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell on floor at bedside	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10 7/25 1956 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown Home		20f. (City or town) Hagerstown (County) Wash Md (State) Md	
21. I certify that I attended the deceased from July 25, 1956, to Aug 27, 1956, that I last saw the deceased alive on Aug 27, 1956, and the death occurred at 11:30 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer		ADDRESS (Street, city or town, state) Clear Spring Md	
PHYSICIAN'S NAME (Type) David R. Brewer		DATE SIGNED 8/29/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-29-56	
22c. NAME OF CEMETERY OR CREMATORIAL Dunkard Cemetery		22d. LOCATION (City, town, or county) Broeafordine, Maryland (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert K. Coffman-Hagerstown, Maryland		24a. REC'D BY REGISTRAR Date 8-29-56	
24b. REGISTRAR'S SIGNATURE Jerry M. Trubler			

SHREAU V. S.

$$e^{i\theta} \begin{bmatrix} 1 \\ 0 \end{bmatrix}$$

1920-1921

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8752

CERTIFICATE OF DEATH

68761

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 9 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 322 W. HOWARD ST.				d. STREET ADDRESS 322 W2 HOWARD ST.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle VICTOR	Last STINE	4. DATE OF DEATH	Month AUGUST	Day 30	Year 19 56

5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9/19/1878	9 AGE (in years lost birthday) 77 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JACOB STINE			14. MOTHER'S MAIDEN NAME KATHERINE LIZER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown)		16. SOCIAL SECURITY NO NONE		17. INFORMANT MRS. MARY STINE		Address HAGERSTOWN MD.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Heart Disease - myocardial</i>	INTERVAL BETWEEN ONSET AND DEATH <i>70 yrs</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACTUAL WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>56</i> , to <i>31 Aug</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>29 Aug</i> , 19 <i>56</i> , and that death occurred at <i>5 10 AM</i> , from the causes and on the date stated above.			
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ACTUAL SIGNATURE <i>F. F. Lusby</i>	20d. ADDRESS (Street, city or town, state) <i>2314 Pittman</i>	20e. ADDRESS (Street, city or town, state) <i>Hagerstown Md.</i>
PHYSICIAN'S NAME (Type) <i>F. F. Lusby</i>		20f. ADDRESS (Street, city or town, state) <i>31 Aug 56</i>

22a. BURIAL, CREMATION, REMOVED (Specify) BURIAL	22b. DATE THEREOF 9/1/56	22c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEM.	22d. LOCATION (City, town or county) GREENCASTLE	(State) PENNA.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Hornbeck, Hagerstown, Md.</i>		ADDRESS <i>100 W. 4th St.</i>	24a. REC'D. BY REGISTRAR <i>Sept 8, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Robert Bowers</i>

BUREAU V. G.
REGISTRY

SEP 6 1956

D.R. G. VAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8784

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 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429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 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1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 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1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1421

BLUENOSE
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1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

S. Robert Wells, M.D. 8/29/56

DATE Wrote in

CERTIFICATE OF DEATH

68763

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		8753	MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		
Washington					Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Hagerstown		2 weeks		Rural Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington County Hospital							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Blanche				Terpenning	Aug	24	19		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-79		9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	
f		W				77	0	0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own home		New York State		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Calvin Goodnuf		Margaret Cornell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		none		Mr. N.O. Terpenning		Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiovascular Collapse		INTERVAL BETWEEN ONSET AND DEATH MIN.			
DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Arteriosclerosis Generalized.		yrs,			
DUE TO		cause (b), stating the under- lying cause last. (c)		Age.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Fractures of Femur and radius and ulnar right side.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		Fell while walking to bathroom					
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hagerstown		(County) Wash	(State) Md.
Aug 17 1956									
21. I certify that I attended the deceased from Aug 17, 1956, to Aug 24, 1956, that I last saw the deceased alive on Aug 24, 1956, and that death occurred at 4:10PM, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) DATE SIGNED									
M.D. 119 E. Antietam St. Hagerstown 8-24-56									
ACTUAL SIGNATURE		Louis G. Griff, M.D.							
PHYSICIAN'S NAME (Type)		Louis G. Griff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial		August 28, 1956		Jefferson Evergreen Cem.		Jefferson, New York			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Merwyn C. Bass		Taneytown, Maryland		Aug. 28, 1956		Chas. Bowers			

RECEIVED

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RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68764

8751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		c. LENGTH OF STAY IN 1b life time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 58 Bloom Alley			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Florence		First	Middle	Last	4. DATE OF DEATH Thomas	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov 25 1891	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Hagerstown, Md		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Richard Butler		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Helen Baltimore 58 Bloom Alley.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO		Tuberculosis meningitis				INTERVAL BETWEEN ONSET AND DEATH 8-10 day			
(b) DUE TO		Disseminated pulmonary TB				Unknown			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis generalized						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Oct 9, 1945, to Aug 7, 1952							
20c. TIME OF INJURY Hour a. p.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 145 W. Wash. St., Hagerstown, Md.		20f. (City or town) Hagerstown		(County)	(State)
21. I certify that I attended the deceased from Oct 9, 1945, to Aug 7, 1952 that I last saw the deceased alive on Aug 7, 1952 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 W. Wash. St., Hagerstown, Md.								DATE SIGNED Aug. 10, 1956	
ACTUAL SIGNATURE L.L. Packer, Jr. M.D.									
PHYSICIAN'S NAME (Type) L.L. Packer, Jr. M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-1956		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Aug 11, 1956		24b. REGISTRAR'S SIGNATURE Westover			

3. A GENE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

18765
382

Reg. Dist. No.

8755

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 13 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 145 Ray Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 145 Ray Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GREGORY EUGENE THOMAS		First	Middle	Lost	DATE OF DEATH August - 9 - 1956	Month Aug	Day 9	Year 1956	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1956	9. AGE IN YEARS lost (birthday) yrs 13	10. IF UNDER 1 YEAR Months 13	11. IF UNDER 24 HRS Days —	12. IF UNDER 24 HRS Hours —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co. Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY? Hagerstown Wash. Co. Md. U.S.A.			
13. FATHER'S NAME Norman F. Thomas		14. MOTHER'S MAIDEN NAME Ethel V. Marshall		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Norman F. Thomas 145 Ray St. Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 5 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intestinal obstruction.		DUE TO 7.3		Osteogenesis imperfecta congenita.		13 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. —		(b)		Bilateral inguinal hernia		13 days.			
DUE TO —		(c)		Achondroplastic dwarfism.		13 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —
21. I certify that I attended the deceased from July 26, 1956 , to Aug. 9, 1956 , that I last saw the deceased alive on August 9, 1956 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.		ACTUAL SIGNATURE R.A. Bell		M.D.		ADDRESS (Street, city or town, state) 119 North Potomac Street, 8-10-56		DATE SIGNED	
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 10, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery		22d. LOCATION (City, town, or county) Sharpsburg Wash. Co. Md.		(State) —	
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home Boonsboro Md		ADDRESS —		24a. REC'D BY REGISTRAR Aug. 13, 1956		24b. REGISTRAR'S SIGNATURE Miss Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. **119**
Dr. R.A. Bell, M.D.
119 N. Potomac St.

BUCKLEY V. S.

Aug 22 1926

BUCKLEY V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,13,14 Filed G.O. 8-10-56 et

8755

CERTIFICATE OF DEATH

08766
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clearspring, Rt. 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS No Address		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Faye		Middle (Married name: Walker) Irene		Last Wilson		4. DATE OF DEATH Aug. 2 1956	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1914	9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pike Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David H. Wilson			14. MOTHER'S MAIDEN NAME Dessie Painter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cirrhosis of Liver INTERVAL-BETWEEN ONSET AND DEATH 10 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1/56</u> 19 to <u>8/2/56</u> 19, that I last saw the deceased alive on <u>8/2/56</u> 19, and that death occurred at <u>8/2/56</u> 19, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Physician's Name (Type) I. J. Bradley M.D. Physician's Name (Type) I. J. Bradley M.D. DATE SIGNED 8/2/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-2-1956		22c. NAME OF CEMETERY OR CREMATORIAL LURAY VIRGINIA		22d. LOCATION (City, town, or county) Stanley, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE I. J. Bradley by Roy S. Dawson				ADDRESS LURAY VIRGINIA		24. REC'D BY REGISTRAR Aug. 3, 1956	
						24. REGISTRAR'S SIGNATURE Charles Bowes	

RECEIVED
AUG 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8757

CERTIFICATE OF DEATH

18767

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL) HAGERSTOWN		c. LENGTH OF STAY IN 1b 38 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS 136 HIGH ST.		
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First HARRY	Middle JOSEPH	Last WALLING	4. DATE OF DEATH AUGUST 13 1956	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 8/11/1878	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TROLLEYMAN			10b. KIND OF BUSINESS OR INDUSTRY POWER CO.	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH WALLING			14. MOTHER'S MAIDEN NAME LAURA MERCER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-10-4656	17. INFORMANT MR. CHARLES H. WALLING	Address HAGERSTOWN MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 days		
(b) Cerebral arteriosclerosis and vascular hypertension DUE TO			Uncertain		
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/30, 1951, to 8/13, 1956, that I last saw the deceased alive on 8/13, 1956, and that death occurred at 6:55 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>John B. Kneisley</i>		M.D. 148 West Washington Street 8/14/56			
PHYSICIAN'S NAME (Type) Dr. B. B. Kneisley		Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEM.	
22d. LOCATION (City, town, or county) FREDERICK		22e. LOCATION (City, town, or county) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Norman, Hagerstown, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR Aug. 16, 1956	
24b. REGISTRAR'S SIGNATURE <i>Frank H. Bowers</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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Aug 20 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68768

8758

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 20 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) JAMES		d. STREET ADDRESS 306 W. WILSON BLVD.	
First MIDDLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONTRACT PAINTER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
13. FATHER'S NAME JOHN HENRY WERKING		14. MOTHER'S MAIDEN NAME MARY YOUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-05-6599	
17. INFORMANT MRS. ORPHA K. WERKING		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 44-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) HAGERSTOWN (State) M.D.	
21. I certify that I attended the deceased from Jan 1 , 1957, to 8-12 , 1958, that I last saw the deceased alive on 8-12 , 1958, and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert P. Corrada		ADDRESS (Street, city or town, state) 137 W. Washington	
PHYSICIAN'S NAME (Type) Robert P. Corrada		DATE SIGNED 8-13-58	
22a. BURIAL, CREMATION, REMOVAL BURIAL		22b. DATE THEREOF 8/15/56	
22c. NAME OF CEMETERY OR CREMATORIAL Best Haven CEM.		22d. LOCATION (C. ty, town, or county) HAGERSTOWN (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Kornament		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR Aug. 16, 1958		24b. REGISTRAR'S SIGNATURE James J. Corrada	

BUREAU V. S.

Aug 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 188769									
8759					CERTIFICATE OF DEATH				
Reg. Dist. No. 302									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital					d. STREET ADDRESS 152 S. Mulberry St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jacob Milton Wilhide		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min	
male	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 22, 1872						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) candy maker			10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Middletown, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Wilhide					14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no		16. SOCIAL SECURITY NO. none		17. INFORMANT Milton Wilhide		Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Coronary Arteriosclerosis (c) DUE TO 5 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour o. p. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown		(County)	(State)	
21. I certify that I attended the deceased from <u>6/1/53</u> , 19, to <u>8/13/56</u> , 19, that I last saw the deceased alive on <u>8/13/56</u> , 19, and that death occurred at <u>8:00</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>S. Earl Young</u> PHYSICIAN'S NAME (Type) <u>S. EARL YOUNG MD.</u> ADDRESS (Street, city or town, state) <u>HAGERSTOWN, MD.</u> DATE SIGNED <u>8/14/56</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-16-56		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran			22d. LOCATION (City, town, or county) Middletown		
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.					24a. REC'D BY REGISTRAR Aug. 16, 1956 24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>				

BUREAU V. S

AUG 20 1956

REGEVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8785 It m 9 - film 6201 8-16-56 L CERTIFICATE OF DEATH 118770706
 Reg. Dist. No. 118770706

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade		c. LENGTH OF STAY IN 1b 2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade	
3. NAME OF DECEASED (Type or print)		First Louisa	Middle Blanche
4. DATE OF DEATH		Month August	Day 11, Year 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	July 19, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
House Wife			Sabillasville Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Josiah Moser		Sarah Jane McClain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No			mrs H. Raymond McClain Cascade Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 Months	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Carcinoma - Generally -	
(b)		2 years	
DUE TO Carcinoma of the right ovary		8 years	
(c) Carcinoma of the right ovary			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Robert A. Ferguson</i>		M.D. Blue Ridge, Pennsylvania, Pa. 11 Aug 56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/56	
22c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge		22d. LOCATION (City, town, or county) Thurmont, Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter W. Groves, Waynesboro Pa.</i>		24a. REC'D BY REGISTRAR DATE	
		24b. REGISTRAR'S SIGNATURE <i>A. H. Hedrich</i>	

RECEIVED
SHEREAU V. S.

AUG 14 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8760

CERTIFICATE OF DEATH

08771
307

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE						
Washington MARYLAND		Md. Wash.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 days						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg						
3. NAME OF DECEASED (Type or print)		First	Middle					
Harry		Edwin	Wolfe					
4. DATE OF DEATH		Month	Day					
		August	18					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 5, 1875	81 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
farmer		own farm		Washington Co. Md.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
William Wolfe		Nancy Maugans						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		- -		Mrs. Della Wolfe, Smithsburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Arrest						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.								
(b)		Ventricular Fibrillation					15 min	
DUE TO (c) Hypertensive Heart Disease								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
3/1 1955								
alive on 8/18 1956								
21. I certify that I attended the deceased from		3/1 1955 to 8/18 1956		that I last saw the deceased		ADDRESS (Street, city or town, state)		
actual signature		Charles F. Hess		M.D.		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Aug. 21, 56		22c. NAME OF CEMETERY OR CREMATORIAL Welty's Cemetery		22d. LOCATION (City, town, or county) Greensburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE 221956		24b. REGISTRAR'S SIGNATURE Chas. Barnes		
Scott F. Minnich & Son, Smithsburg, Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8751 CERTIFICATE OF DEATH

Reg. Dist. No. **08772**

1

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 32 years		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1400 Oak Hill Ave.		e. STREET ADDRESS 1400 Oak Hill Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harvey Upton Yeater		First	Middle	Last	4. DATE OF DEATH August 28	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1892	9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dental		11. BIRTHPLACE (State or foreign country) Cameron W. Va.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Christopher E. Yeater		14. MOTHER'S MAIDEN NAME Florilla Teagarden							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Ruth Yeater		Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH 13 hrs.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis with Anginal Syndrome									
DUE TO (c) ---									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 148 West Washington Street		20f. (City or town) (County) (State) 148 West Washington Street			
21. I certify that I attended the deceased from Nov. 6 , 1954, Aug. 28, 1956, that I last saw the deceased alive on August 27 , 1956, and that death occurred at 8:10 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 148 West Washington Street			
ACTUAL SIGNATURE <i>B. B. Kneisley</i>						DATE SIGNED 8/29/56			
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-56		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Sept. 4, 1956		24b. REGISTRAR'S SIGNATURE <i>W. H. Powers</i>			

BUREAU V. S.

SEP 6 1956

RECEIVED